Article

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Introduction

This paper has been generated from a primary research study carried out during 2015; 'making sense of childbirth choices; exploring the decision to freebirth in the UK'. Freebirthing is characterised by a woman's *intentional* decision to give birth without attendance by a midwife or doctor, even where there is access to maternity services. This characterisation precludes women; who give birth before arrival (BBA) to maternity services (Loughney et al., 2006) (either before arrival to hospital, or before the arrival of a homebirth midwife), women who have been denied a homebirth midwife by the local Trust (Plested and Kirkham, 2016), or women who have a concealed pregnancy (Friedman et al., 2007). Freebirthing raises concerns with health professionals, where there is potential morbidity or mortality to either the mother or baby (Holton and de Miranda, 2016). Freebirthing also raises concerns regarding the inadequacy of maternity systems to meet the needs of childbearing women (Dahlen et al., 2011; Holton and de Miranda, 2016).

A systematic metasynthesis review of the literature (Feeley et al., 2015) identified only four primary studies; n=1 Australia, n=3 US. The findings suggested that women chose to freebirth as a way of rejecting both the medical and midwifery model of birth, to reclaim and assert autonomy and agency during birth, and women reported a faith in the birth process. There are known variations of healthcare systems between the UK and that of the US and Australia, for example, the UK has a strong midwifery workforce and culture that is supported by a free healthcare service and governmental policies. The UK also has robust legislation supporting women's autonomous decision-making, including the right to decline recommended treatment or care (Birthrights, 2013a) and the legal right to freebirth (Birthrights, 2013b; Nursing and Midwifery Council, 2012). However, at that time, whilst anecdotal data suggested a growing incidence of freebirthing in the UK (Edwards and Kirkham, 2013), no primary studies had been published. Thus situating the context of the original primary study, to explore the phenomenon of freebirthing within a UK context using an interpretative hermeneutic phenomenological approach.

Moreover, embedded into the original research aims was to share the findings to a wider audience via a range of dissemination activities. This was felt to be important as ongoing familiarisation with the wider literature and during my midwifery clinical experience, it appeared that the phenomenon of freebirthing was often misunderstood. As such, the purpose of this paper is twofold; firstly, using my research into freebirthing as a case study, I will demonstrate the use and benefits of interpretative hermeneutic phenomenology to midwifery and nursing research to generate knowledge for the benefit of service users, healthcare professionals, researchers and policy-makers. Secondly, I will discuss the activities I carried out to enhance dissemination and impact for the benefit of service users and clinicians.

Adopting an interpretive hermeneutic phenomenological approach

This study adopted an interpretative hermeneutic phenomenological approach to the research design, methods and analysis. Positioning the study within an interpretative phenomenological methodology is integral to understanding both the research processes and knowledge generated, as philosophy guides the research methods and influences the knowledge that is generated (Grant and Osanloo, 2015). Phenomenology is a discipline that is both a method of inquiry and a philosophical view of the world that broadly focuses upon the lived experiences, meaning-making and the contextual realities of human beings (Husserl, 1970; Heidegger, 1962; Gadamer, 1960; Ricoeur, 1991). However, within this broad definition of phenomenology, there are rich and complex variations of theoretical approaches (van Manen, 2014). Whilst it is beyond the scope of this paper to explore the complex variations of phenomenology, the following describes and justifies my use of an interpretative hermeneutic approach.

Interpretive hermeneutic phenomenology is a particular philosophical approach developed by Heidegger (1962) and further developed by Gadamer (1960) and later Ricoeur (1991) (amongst other scholars) that looks beyond the description of a phenomenon to explore meanings embedded within. Its aim is not to seek a unified 'truth' but to reveal the complexity of human experience that relates to a particular phenomenon (Heidegger, 1962; van Manen, 2014). Emphasis is placed on the subjective experience of the participant, integrating a person's socialisation,

enculturation and interpretation of the world to reveal the meanings they attribute to their experience (van Manen, 2014). The illumination of an individual's sense-making and meanings offers researchers an insights into people's experiences, motivations and actions (Thomson et al., 2011; Regan, 2012).

Whilst there are many conceptualisations within interpretative hermeneutic phenomenology that require understanding, here, I provide a brief overview of some of those concepts. Heidegger's (1962) concept of *'lifeworld'* related to the notion that the nature of human experiences is intrinsically entwined within historical, cultural, political and social influences. These influences are perceived to provide the basis in which a person comes to engage, understand and make sense of their *'lifeworld'*. As such, Heidegger's (1962) notion of *'being-in-the-world'* means that one cannot separate those influences from experience. Moreover, these notions are also related to the hermeneutic concept that humans are self-interpreting beings (Heidegger, 1962),that assumes life experiences are processed as an ongoing interpretative act embedded within historical, sociocultural influences (Heidegger, 1962; Gadamer, 1960). This includes the role of the researcher whereby preconceived notions known as *'pre-understandings'* (Heidegger, 1962), are not seen as separate, but as part of the interpretative examination of the phenomenon under focus. Rather than attempting to bracket pre-existing notions, a researcher brings them to the fore as a starting point of the interpretative analysis known as the hermeneutic circle (Heidegger, 1962). This is an important divergence from other phenomenological approaches, notably Husserlian (1970) phenomenology, where it is perceived it is possible to seek out the essence of *'the thing itself',* that sits beyond such influences, and whereby it is perceived possible to *'bracket'* preconceived notions of the phenomenon under scrutiny.

Hans-Georg Gadamer (1900-2002) developed Heidegger's ideas further and further conceptualised the researcher's own experience of reading and understanding to be an integral part of the interpretative process in which the relating concepts of pre-suppositions, inter-subjectivity, authenticity (trustworthiness), temporality (time affecting understanding/emotion), tradition, and history to interpreting the written word (Gadamer, 1960; Regan, 2012). As such, both the participant in sharing their

experiences and the researcher listening to them (and later during the transcription/analytical process) are in a continuous space of interpretation (Gadamer, 1960). Through a continual process of reflection and interpretation, the participant's accounts are considered individually and as part of the whole, whereby the researcher produces a tentative interpretation of the phenomenon in focus (Regan, 2012; Gadamer, 1960).

Applied to this study, I felt that interpretative hermeneutic phenomenology (as informed by Heidegger and Gadamer) was appropriate to explore the lived experiences of decision-making for women who had chosen to freebirth. The philosophical approach aligned with my worldview that human experiences are embedded within a complex relationship between socialisation, enculturation and individual interpretations of their personal lifeworlds. Additionally, some researchers consider an alignment between interpretative hermeneutic phenomenology and that of a midwifery philosophy of practice i.e. a holistic approach to care that considers the woman within both a biopsychosocial model, mirroring the conceptualisation of 'lifeworld' (Thomson et al., 2011; Miles et al., 2013). Furthermore, interpretative hermeneutic phenomenology has been successfully used in a range of nursing and midwifery research studies (Lopez and Willis, 2004; Thomson, 2007; Smith et al., 2010; Longworth and Kingdon, 2011; Miles et al., 2013). Thus strengthening the case for using it as a research approach.

Applying the research approach

Ethical approval was obtained from one of the ethics sub-committees at the author's institution, and an amendment was approved in January 2015 (project number: STEMH 208). The primary study was carried out in 2015 and recruited n=10 consenting participants into the study via social media and email groups. The sample number was appropriate for the research design (Smith et al., 2010). Data collection comprised of two components: a self-written narrative about their decision-making with a follow-up interview or an interview only. Nine of ten participants wrote a narrative and all were interviewed. The sequential method of data collection provided two opportunities; the participants could self-direct their narratives which provided an insight to the areas of significance that were important to them individually with limited input from me, the

researcher. Secondly, I was able to 'get to know' the participant's story by pre-reading the narrative, making notes, reflections, and making early analytical interpretations to be explored in the interview. Moreover, the self-written narratives provided rich data that ranged between 2-7 typed pages of text (841-3624 words), indicating that it was an acceptable method of data collection. Interviews lasted from 30 minutes to 2 hours, and one was conducted via an encrypted chat room at the participants' request. A semi-structured interview style was adopted where questions were individualised for each participant and were primarily open-ended questions to encourage further dialogue based on the narrative provided.

Data analysis was carried out in a number of iterative stages. Following transcription, both the self-written narrative and interviews were uploaded to MAXQDA (maxqda.com, 2015), a qualitative software data programme designed to manage large quantities of data. Each piece of data was coded line by line - significant phrases were highlighted as part of an 'in-vivo' method whereby poignant descriptive phrases were interpreted to create a code. This continued iteratively data was read and no new codes were developed. Following the coding, an iterative writing process was carried out as I attempted to bring together the individual accounts together with my interpretations of their contextual meanings across the data set. Looking for convergences and divergences within the data, and through a back and forth process between the original data, codes and further writing, tentative interpretations were explored. Through this process, a deeper level of immersion in the data, interpretative insights developed a synthesis, a 'fusion of horizons'(Gadamer, 1960) that brought together the individual participants into a 'whole', represented as interpretative themes.

Following analysis, participants were invited to provide feedback on the findings to confirm I had adequately captured their meanings associated with the decision to freebirth. Whilst member checking is contentious within hermeneutic phenomenology due to the interpretative processes (Bradbury-Jones et al., 2010), I purposefully deployed member checking as a way of forging and maintaining trusting relationships with the participants- a potentially vulnerable group due to the subversive nature of freebirthing. Therefore, I felt it was important that they retained a

sense of ownership by reviewing the findings to ensure I had adequately captured their perspectives. As such, during member checking, the participants were provided with the overall findings, the integrated analysis across all of the participants, not just in relation to their own experiences. The provision of the overall findings was a pragmatic decision due to the time constraints of the study, and was also derived from the participants reported interest in the final findings during the interviews and email communications. It created the space for the participants to view their experiences in relation to the others, and offered a means of further participation. This method of member checking appeared to be acceptable to the participants as six participants responded with positive feedback, for example:

> *'I enjoyed the consolidation of a variety of viewpoints and reasoning's for choosing freebirth, it further highlighted to me how unique birth choices are. I resonated more with some themes over others. There are very nuanced differences in the decision making process and I think your overview goes some way to addressing this and highlighting, what I feel, is its significant relevance.'* (Alex, pn-8, email correspondence.)

Knowledge production: Revealing complexities and unexpected findings

The initial study generated rich, detailed and nuanced data regarding the variety of decision-making paths that led women to freebirth. Whilst the detailed findings have been reported elsewhere (blinded for review), overall the 10 women had collectively experienced 33 births including 15 freebirths with no adverse outcomes (at the time of the study, two women were pregnant and had further successful freebirths). Therefore, the women had vast and variable experiences of childbearing and interactions with maternity services. This study found that even with a sample size of 10, there were different and complex reasons that drove decision-making which generated three main themes from the data; *Contextualising herstory* describes how the participants' backgrounds (personal and/or childbirth related) influenced their decision making. *Diverging paths of decision-making* described detailed insights into how and why women's different backgrounds and experiences of childbirth and maternity care influenced their decision to freebirth. *Converging path of decision making*, outlined the commonalities in the women's narratives in terms of how they

sought to validate their decision to freebirth, such as through self-directed research, enlisting the support of others and conceptualising risk.

To illustrate some of the differences between the participant's accounts, here I present three examples from the theme '*diverging paths of decision-making'*. One woman had a traumatic hospital birth the first time and opted for a homebirth the second time as a way of seeking to overcome the psychological trauma. Her homebirth was a positive, empowering experience with midwives. However, she expressed a long-held desire to freebirth but only found the courage and faith in her body following the successful homebirth. Therefore, in her third pregnancy, she opted for freebirth:

> *'I think in hindsight I probably needed to prove to myself I was capable of doing it before contemplating doing it alone.'* (June, pn-6, narrative).

Conversely, another participant experienced a traumatic hospital birth the first time, and also expressed the desire to homebirth the second time. However, she found her community midwives obstructive, fearful and resorted to coercive tactics to encourage the participant to birth in hospital. This poor experience of community midwives compounded the participant's previous birth trauma, facilitating the decision to opt out of all care and to freebirth:

> *'The obstructive behaviour by the community midwives, the lottery of who would turn up at the birth. If their behaviour was indicative of many of the midwives in the Trust, then I could not trust that they were supportive of home births. I actually became fearful that they would turn up in time for the birth as they seemed more scared of attending a home birth than I felt about having a home birth.'* (Cat, pn-9, narrative).

Different again, another participant was a primiparous woman and had opted to freebirth early in her first pregnancy, a decision that was driven by an instinctual desire to birth alone:

> *'I hadn't really explicitly thought about where/how to give birth before then, but if I had, I would have identified immediately that it wouldn't be in hospital, and I*

didn't want anyone else around. So as soon as I came across the concept, it made complete sense to me.' (Claire, pn-3, interview).

Moreover, the participant's accounts revealed unexpected data such as the experience of significant tensions and conflicts with maternity caregivers once the decision to freebirth had been made (blinded for review). Therefore, a secondary analysis was carried out to capture the participants lived experiences following the decision to freebirth. The findings generated three key themes; '*violation of rights'* that highlighted the conflicts women faced from maternity carers who were unaware of women's legal rights to freebirth, conflating this choice with issues of child protection. '*Tactical planning'* described some of the strategies women used in their attempts to achieve the birth they desired and to circumnavigate any interference or reprisals. The third theme, '*unfit to be a mother'* described distressing accounts of women who were reported to social services.

To illustrate the findings with data, I present an exemplar quote from each theme. All of the women were aware of their legal rights to freebirth (Birthrights, 2013b) and to opt out/decline any care of their choosing (Birthrights, 2013a). However, several participants found that this was not respected or understood by midwives that was central to the theme of *'violation of rights'* which is expressed here:

''I think I told her either immediately, or maybe at the second appointment, that I intended to freebirth (although I didn't know that term then, so I was calling it unattended birth). She informed me (incorrectly of course) that it was illegal... I now know that the official NHS position on freebirth is that midwives should support it as a valid choice. But I didn't then, so I couldn't show her that document, and it was frustrating (and I even felt bullied at times) to have to fight my corner during every interaction with health professionals." (Claire, pn-3 interview).

To circumvent negative reprisals, the second theme highlighted that some women resorted to 'tactical planning' such as planning a birth before arrival (BBA) as to not arouse suspicion:

''Well I know quite a few people that I don't know in real life but in online groups who have had freebirths who haven't called the midwife out afterwards have been referred to social services for putting their babies at risk and have had social services and police turn up at their door and that is not something that I want to happen. So we made the decision to have the baby on our own and call out the midwife afterwards and just pretend it happened so quickly they didn't get there in time. Or not that they didn't get there on time, but we didn't have time to ring before". (Jane, pn-4, interview).

However, four women experienced a statutory referral to social services despite the legality of freebirthing in the UK (Birthrights, 2013b) and felt stigmatised as captured in this third theme as 'unfit to be a mother':

'My midwife referred me to Social Services for opting out. This situation did not resolve itself until after the birth, where it culminated in, what I feel was a violation of my rights and privacy. I feel this is important to mention this as it profoundly affected my transition to motherhood leaving a lingering imprint and I was more than ever, grateful for my wonderful birth to keep me grounded.' (Alex, pn-8, narrative).

Therefore, the findings raised important human rights issues (Birthrights, 2017), as the participants revealed, legal and ethical frameworks of care were not respected.

The relevance of the findings from both iterations of research questions identified key implications for women's experiences, clinical practice, education and policy-makers. Whilst the number of participants were small and not generalisable, the findings are likely to be transferrable to other high-income settings that relate to the phenomenon. Moreover, the findings suggested resonance with other studies, for example, previous research highlights how women choose elective caesareans due to a previous poor experience (Lavender et al., 2006), or how women opt for a homebirth following a traumatic caesarean birth (Keedle et al., 2015), or homebirth with significant risk factors following traumatic NHS care (Symon et al., 2010; Holton and de Miranda, 2016) or even forgoing subsequent children such is the extent of their previous traumatic experience (McKenzie-McHarg et al., 2015).

As such, implications from the study findings were identified: for maternity services, the findings suggested that *some* women were unable to get their needs met, particularly those who had experienced a traumatic birth. Conversely, for some women, the decision to freebirth was borne from a positive positioning, informed by a philosophical belief and preference to birth without midwives. For these women, they required supportive, sensitive communication to ensure women did not fear reprisal. For midwives, the findings suggested that the midwifery philosophy of woman-centred care was not always carried out, leaving women to feel disillusioned with maternity services. For educators, improved awareness regarding the legalities around freebirthing and autonomous decision-making. For policy-makers, the rhetoric of woman-centred care needs to be addressed through staffing, availability of services (i.e. homebirth, debriefing) and clinical practice.

Dissemination and Impact

Central to all healthcare research is the dissemination - the communication of research findings. Impact is the use of research findings beyond academia so it can be used to benefit a wider audience (Keen and Todres, 2007). Therefore, dissemination is an active task of applying research into clinical practice, policy, and education (Keen and Todres, 2007). However, critics suggest that dissemination activities are often limited to a journal publication and/or conference presentations (Barnes et al., 2003; Keen and Todres, 2007). The proliferation of qualitative research faces particular criticism that researchers lack the knowledge or skills to demonstrate practical, communicable usability of research findings (Barnes et al., 2003), thus, limiting the potential impact of research. Dissemination and impact were key aims from the start of the study for several reasons; firstly, the study was an opportunity to offer women a platform in which their voices could be heard. Secondly, to raise awareness and understanding for maternity professionals regarding the complexity of such decision-making and to clarify the legalities in association with human rights and social services. Thirdly, as a means to provide evidence-based information to support midwives in clinical practice should a woman disclose an intention to freebirth.

Whilst direct impact is difficult to assess, here I present the key dissemination activities as 'routes to impact' (University of York, 2016). Activities began with two

journal publications (blinded for review), of which one was supported by grant funding to pay for open access publication. Advantages of an open access publication include increased visibility and usage of the research study (Nature, 2018) and greater public engagement (Cambridge University Press, 2018). Furthermore, I allocated time to facilitate the dissemination of the open access paper where I directly shared the paper; firstly, with the participants and the online freebirthing groups that had advertised the study. Secondly, using social media the paper was disseminated across a number of social media midwifery and birth worker online groups, reproductive research interest groups and Research Gate (a social media platform for academics). Additionally, the journal provided an opportunity to write a blog relating to the first publication. The blog was a plain language summary of the study findings alongside implications for women, maternity professionals and maternity services. Again, I allocated time to disseminate the blog (linked to the publication) across social media groups to enhance the visibility and potential usage of the research findings.

The two publications generated significant interest amongst social media users and professional networks. The interest was captured by the Conversation, an independent news outlet sourced from the academic and research community, who requested an article of a lay summary of the issues related to freebirthing. I wrote an overview of the phenomenon of freebirthing, incorporated the findings of my study and that of others published at similar times. The article for the Conversation was reprinted in the Independent and the Sun online newspapers. Additionally, I approached the RCM Magazine, in which I fulfilled one of the main aims of dissemination, a publication aimed at midwives in clinical practice (blinded for review). The article was written to outline the issues that related to the research findings and to provide structured advice regarding practice issues related to freebirthing. Coinciding with the article aimed at midwives, I worked with a local trust to support the development of guidelines regarding women's choice to freebirth. The purpose of the guideline was to provide a mechanism of knowledge and support for the community midwives and the women in their care.

Dissemination activities also included national and international conference presentations of both publications and a submission of the findings to the Better

Births Maternity Review (NHS England, 2016). Additional activities included attending community midwifery groups at two local Trusts and student midwives at three universities. The purpose of the talks was to raise awareness of women's decision-making, women's experiences and the legalities of freebirthing. The talks were part presentation and part open discussion where midwives' and student midwives' concerns could be raised and discussed within a positive, open environment. Discussions included how midwives can support women in their choices whilst fulfilling their professional responsibilities. Moreover, the talks revealed the wider applicability of the research findings for *all* choices women make. Through an opportunity to discuss the legalities of freebirthing, the human rights in childbirth framework were revisited offering renewed awareness of women's rights and midwives' professional, ethical and legal obligations (Birthrights, 2017). Informal feedback from the participants was positive and it was reported that midwives'/student midwives felt greater confidence in supporting women's autonomous decision-making.

Conclusion

Using my research of freebirthing, this paper has presented a case for the use and benefits of interpretative phenomenology. A strength of interpretative phenomenology, as demonstrated, is the capacity to elicit rich, detailed and complex insights into an under-represented phenomenon. The knowledge generated from the study raised important issues regarding the impact of women's birthing experiences, interactions with healthcare professionals and motivating factors towards such a choice. Such insights have raised implications pertinent to women, maternity professionals, educators and policy-makers. Whilst small-scale, the study was an opportunity for women to voice the unheard, and the findings offered an exploratory commentary in which to open up space for further dialogue, clinical reflection and research. Moreover, I have presented methods of dissemination that facilitated the wider access to the research findings. Although the dissemination activities could be pertinent to any study, I suggest that it was the depth of insights generated from an interpretative phenomenological study that captured the interest of a wider audience.

Key points

- Interpretative phenomenology is a philosophical and methodological research approach that can be applied to a range of nursing and midwifery clinical research investigations.
- Using a research study that explored the phenomenon of freebirthing, I have demonstrated the benefits of using interpretative phenomenology to generate rich and complex data regarding an under-researched area.
- This research study highlighted that a small qualitative study can be used to inform clinical practice, education and policy-making. However, the onus is on the researcher to plan and implement a variety of dissemination activities to enhance impact.

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Declaration of Conflicting Interests

The Author declares that there is no conflict of interest.

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Ethical approval

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